

DECEDENT INFORMATION FORM

Patient's Full Name (Last, First) if Known: _____

INCIDENT NAME		OPERATIONAL PERIOD		
MEDICAL RECORD/ TRIAGE #	DATE	TIME	LOCATION PRIOR TO STORAGE	
FIRST NAME	MIDDLE NAME	LAST NAME	AGE	GENDER
IDENTIFICATION VERIFIED BY <input type="checkbox"/> DRIVERS LICENSE <input type="checkbox"/> STATE ID <input type="checkbox"/> PASSPORT <input type="checkbox"/> BIRTH CERTIFICATE <input type="checkbox"/> OTHER: _____ IDENTIFICATION #: _____ IF IDENTITY IS UNKNOWN, WHAT ARE THE OTHER IDENTIFIERS (SKIN MARKINGS, TATTOOS, ETC.) IF ANY?				
ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)				
MAC NOTIFIED VIE REDDINET/PHONE <input type="checkbox"/> YES <input type="checkbox"/> NO		RECORD CREATED IN EDRS <input type="checkbox"/> YES <input type="checkbox"/> NO		DEATH CERTIFICATE SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO
PHOTO ATTACHED ON THIS FORM <input type="checkbox"/> YES <input type="checkbox"/> NO		FINGERPRINTS ATTACHED TO THIS FORM <input type="checkbox"/> YES <input type="checkbox"/> NO		
NEXT OF KIN NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME	RELATIONSHIP	CONTACT TEL	
FINAL DISPOSITION	DATE/ TIME	NAME OF RECIPIENT	SIGNATURE OF RECIPIENT	
RELEASED TO: <input type="checkbox"/> CORONER <input type="checkbox"/> COUNTY MORGUE <input type="checkbox"/> MORTUARY <input type="checkbox"/> OTHER: _____				
<input type="checkbox"/> LIST OF PERSONAL BELONGINGS PROVIDE THE FOLLOWING ORIGINAL AND COPIES IF THIS FORM: <input type="checkbox"/> ORIGINAL ON FILE IN DECEDENT AFFAIRS GROUP <input type="checkbox"/> COPY WITH DECEDENT <input type="checkbox"/> COPY TO MEDICAL CARE BRANCH DIRECTOR			STORAGE LOCATION OTHER RELIGIOUS/CULTURE NOTES:	